471-000-519 Nebraska Medicaid Practitioner Fee Schedule for Podiatry Services

To Determine the Medicaid Allowable:

1. IDENTIFY THE CODE. First, identify the correct code for the Podiatry item. Refer to the latest HCPCS Level II Expert book for code descriptions. Every provider should have this guide. In addition, the following website is a useful tool for identifying the HPCPS code for a particular item:
   http://www3.palmettogba.com/dmecs/do/hcpcssearch
   If a type of item has a HCPCS code assigned, the provider must use that code when billing, and not any "miscellaneous" code.

2. IDENTIFY AND FIND THE CODE/MODIFIER COMBINATION. Review the Procedure Code Modifiers (next page) and select the modifier that is correct for the item being billed. Click on the  binoculars located in the left chimney and search for the code.

3. LOCATE THE MEDICAID ALLOWABLE FOR THE PROCEDURE CODE.
   If "BR" or "RNE" is listed, see Step #5 for special pricing.

4. PAYMENT IS THE LOWER OF THE FEE SCHEDULE MEDICAID ALLOWABLE OR THE PROVIDER'S SUBMITTED CHARGE. The provider's submitted charge must reflect your charge to the general public. Provider must not bill Medicaid more than it charges the general public.

5. SPECIAL PRICING. Certain procedure codes will not have a MEDICAID ALLOWABLE:

   - "BR" (By report) – Paid at "reasonable rate" based on the service and circumstances. A complete description of the service is required for review.
   - "RNE" (Rate Not Established) - Paid at "reasonable rate" based on the service
   - "IC" (Invoice cost) - Paid at "invoice cost". An invoice must be attached to the claim. Some services may also have an associated maximum allowable.

   Provider must not bill Medicaid more than it charges the general public, must maintain documentation of usual and customary charges, and provide it to the Department upon demand. If the service requires Prior Authorization (indicated by an "*") submit Manufacturer's Suggested Retail Price (MSRP) with the Prior Authorization request. Claims for services Prior Authorized by Primary Care Plus (for Medicaid Managed Care Clients in the Primary Care Case Management Plan) must include an MSRP.

6. PRIOR AUTHORIZATION. Some Podiatry services may require Medicaid approval of a prior authorization request. Provider must submit a Form MS-77, found in the Title 471 Appendix http://www.dhhs.ne.gov/reg/appx/atc471.htm, Form Number 471-000-206. Submit Manufacturer's Suggested Retail Price (MSRP) or your actual cost invoice with the Prior Authorization Request.

7. Quantities supplied must be based on medical necessity and are supplies used in the office. There is no billing for take home supplies.

Questions regarding status of Medicaid claims should be directed to the Client Payments and Claims Processing Unit – Medicaid Inquiry at (877) 255-3092 or 471-9128 in Lincoln.

The five-digit numeric codes included in the Schedule are obtained from the Physicians' Current Procedural Terminology (CPT), Copyright 2012, by the American Medical Association. CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. This Schedule includes CPT numeric identifying codes for reporting medical services and procedures, which are copyrighted by the American Medical Association.

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RNE = Rate Not Established BR = By Report IC = Invoice Cost (I) = Interim Value

* Requires Prior Authorization

<u>For procedure codes 10000-69999.</u>
See the Nebraska Medicaid Practitioner Fee Schedule for Physician Services found in NMAP Services 471-000-518. The amount listed is a dollar amount ($). The dollar amount listed is the Medicaid allowable, unless otherwise indicated.

<u>For procedure codes 70000-79999.</u>
See the Nebraska Medicaid Practitioner Fee Schedule under Radiology found in NMAP Services 471-000-518. The amount listed is a dollar amount ($). The dollar amount listed is the Medicaid allowable, unless otherwise indicated.

<u>For procedure codes 80000-89999.</u>
See the Nebraska Medicaid Practitioner Fee Schedule under Pathology found in NMAP Services 471-000-520. The amount listed is a dollar amount ($). The dollar amount listed is the Medicaid allowable, unless otherwise indicated.

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For procedure codes 90000-99999.
See the Nebraska Medicaid Practitioner Fee Schedule for Physician Services found in NMAP Services 471-000-518. The amount listed is a dollar amount ($). The dollar amount listed is the Medicaid allowable, unless otherwise indicated.

For Medical Supplies, Orthotics and Prosthetics (A Codes & L Codes) that are appropriate for use as a Podiatrist see the Nebraska Medicaid Practitioner Fee Schedule for Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics found in NMAP Services 471-000-507. The amount listed is a dollar amount ($). The dollar amount is the Medicaid allowable unless otherwise indicated. No more than two medically necessary orthopedic footwear, shoe corrections, orthotic devices or similar supportive devices for the feet may be provided per visit.

The G0127 Code – trimming of dystrophic nails ANY number, is specific to Podiatry and not found in any other fee schedule. The dollar amount allowable for payment from Nebraska Medicaid is $7.54.

For J codes & Q codes see Nebraska Medicaid Practitioner Fee Schedule for injectable found in NMAP Services 471-000-540. The amount listed is a dollar amount ($). That amount is the Medicaid allowable, unless otherwise indicated. These codes are for office use only; there are no take home supplies.